Government of the District of Columbia
Department of Health

Health Regulation
& Licensing Administration

DEMOGRAPHIC INFORMATION

Business Name of Agency: _____

Website: _____

[Please note: This license shall not be valid for use by any other person or persons or at any place other than that designated in the license Title 22, DCMR, Chapter 49, § 4901.6.]

Pending applications shall not provide or refer nursing personnel, to a health care facility or agency, or to an individual, for the purpose of rendering temporary nursing services within the District of Columbia until you have been issued a license. Processing time can take up to 90 days.

Contact Person

Name: _____

Please keep this contact information current. This is the person that we will contact prior to and after the issuance of your licensure.

Professional Title/DC License Number, if applicable: _____

Telephone Number: _____Email Address: _____

Address: _____

_____

Supervising Registered Nurse

Name: _____

Professional Title/DC License Number: _____

Telephone Number: _____Email Address: _____

Address: _____

_____

Owner/Operator of Nurse Staffing Agency

Name: _____

Professional Title/DC License Number, if applicable: _____

Telephone Number: _____Email Address: _____

Address: _____

_____

Please provide the following information for all that apply:

Registered Business Office:

Telephone Number: _____Email Address: _____

Address: _____

_____

Operations Headquarters:

Telephone Number: _____Email Address: _____

Address: _____

_____

DC Operations Headquarters:

Telephone Number: _____Email Address: _____

Address: _____

_____

If a corporation provide the following information with respect to your **Registered Agency** within the District of Columbia

Registered Agency: _____

Address: _____

Telephone Number: _____

E-Mail Address: _____

If not a corporation, provide the following information with respect to your **Attorney-in-Fact or General Agent within the District of Columbia,** per DC Business Corporation

Attorney-in-Fact or General Agent: _____

Address: _____

Telephone Number: _____

E-Mail Address: _____

ATTACHMENTS

Submit all of the following documents along with a signed copy of your application. Incomplete applications will slow down the review process:

Insurance Verification

☐ Copy of insurance certificate with HRLA added as a certificate holder

Policies and Procedures

☐ Copy NSA's policies and procedures

(Please note: In order to prevent the disclosure of proprietary information please place a disclaimer on any information that you consider proprietary.)

Corporations and LLC's

☐ Copy of Certificate of Good Standing as a corporation from the District of Columbia

Agencies located within the District of Columbia

☐ Certificate of Occupancy issued by the District of Columbia Government for premises on which the office is located

Agencies located outside of the District of Columbia

☐ Copy of each document certifying the responsible jurisdiction's approval of the use of that location or premises as a Nurse Staffing Agency, including all approvals related to zoning, building and fire codes

LICENSES/CERTIFICATIONS/ACCREDITATION

Are you currently licensed, certified or accredited as a NSA by another entity?

☐ No ☐ Yes If yes, please specify licenses, certifications and/or accreditations:

_____

_____

_____

Has another entity suspended, revoked or placed conditions or your license, certification or accreditation as a NSA? ☐ No ☐ Yes If yes, please specify:

_____

_____

SIGNATURE

I attest to the fact that this NSA's records comply with the requirements as specified in Title 22, DCMR, Chapter 49 and that the above statements are true

Print or Type	Date
Signature	Date

LICENSURE FEE & MAILING INSTRUCTIONS

Licensure fee	Duplicate License
$1,000	$50.00

Enclose check or money order MADE PAYABLE TO D.C. TREASURER

PLEASE MAIL APPLICATION, ATTACHMENTS AND LICENSURE FEE TO:

Department of Health
Health Regulation Licensing Administration
Intermediate Care Facilities Division
P.O. Box 37804
Washington, DC 20013